SECTION V

OUR PROGRESS

It has been a challenging first year for the Alliance program with most of the activities focusing on the development of an infrastructure required for effective and efficient care. Despite the initial focus on operational and systems development, HCSNA also identified the need for a long-term strategy for performance measurement focused on specific core areas of the program and based on program mandates where quality assurance and improvement are a priority. An important component of this strategy is the performance measurement system consisting of core performance indicators in broad operational categories. These categories include:

- Access to care
- Quality of care
- Utilization of services
- Customer and provider satisfaction
- Financial performance
- Management/administrative performance

HCSNA, in collaboration with the Alliance partners, has been actively seeking to measure and compile findings for indicators in each of these categories. This section of the report presents the key results that are currently available. Please note that these results cover the first 10 months of the Alliance program and that the information was derived from multiple data sources such as Alliance service reports, Alliance claims reports, and the HCSNA data warehouse.

ACCESS TO CARE

In the initial year of the program, access to care was assessed by monitoring the counts of primary care and specialist providers in the network in relation to the total enrollment. GeoAccess maps were created to visualize the geographic distribution of primary care providers and enrollees within the service area. This tool enables us to see if providers are distributed in accordance with where Alliance members reside.

Primary Care

The map of the distribution of primary care providers is presented in Chart 5.1 on the following page. It indicates that the PCPs are appropriately located where the density of Alliance membership is the greatest.

As of July 2002, the PCP-to-enrollee ratio was one PCP for every 132 enrollees. This measure does not account for patients who have other means of health insurance who are served by these physicians and are not Alliance patients. The result is an underestimate of the true workoad of the physicians serving Alliance patients. To overcome this, HCSNA is working on better measures for monitoring physician workload.

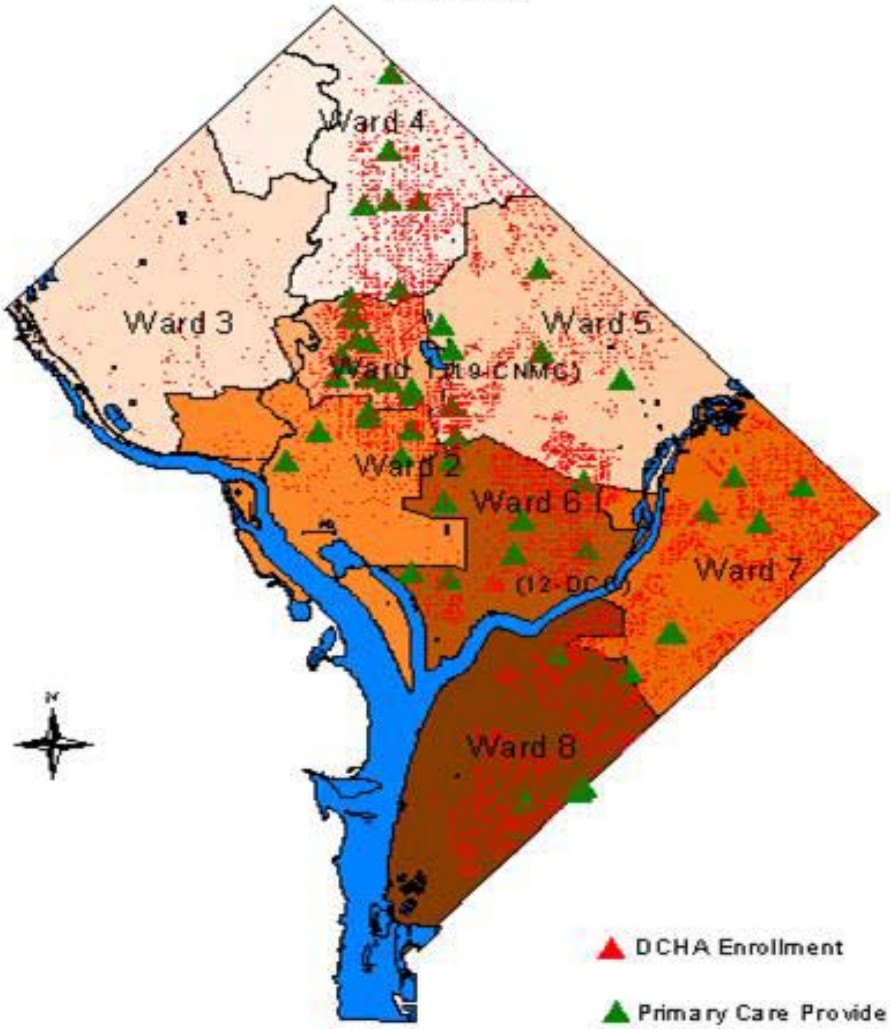
Medical Homes and Primary Care

The primary goal of the plan that created the Alliance called for "providing the volume of medical services available under the Public Benefit Corporation (PBC) to uninsured residents."[1] Vendor requirements for realizing this goal included identifying primary care "homes" for uninsured residents and achieving a 10 percent increase in primary care visits.

[1] The Restructuring Plan for the Public Benefit Corporation Pursuant to the Requirements of the Human Support Services Title of The District Of Columbia Appropriations Act, 2001.

Chart 5.1

DC Healthcare Alliance
Distribution of Enrollment and Primary Care Providers
May 2002



CNMC - Childrens National Medical Center
DCG - DC General

Note: There were 27,436 enrollees.
One hundred and eighty-eight Primary Care providers located at 55 sites.
Source Data: D.C. Healthcare Alliance, Provider Network Data, May 2002.
Source Map: D.C. State Center for Health Statistics Administration.

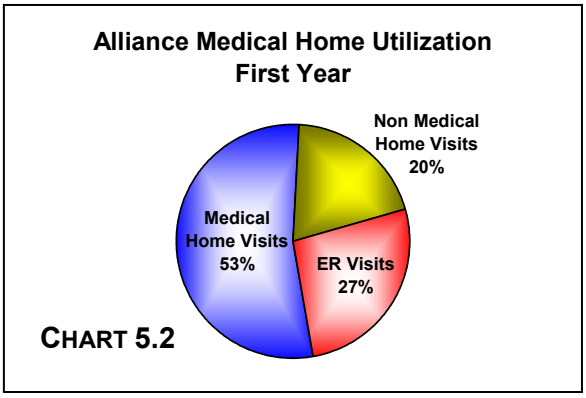
These requirements led to the concept of providing care within the Alliance through a community-based "medical home."

The medical home concept began with the advent of Primary Care Case Management (PCCM) and is best described as providing primary healthcare services in a coordinated, family-centered manner. This method of providing coordinated services was created by the Omnibus Budget Reconciliation Act of 1981. It consists of State Medicaid managed care systems in which the PCP is responsible for approving, coordinating, and monitoring the care of enrolled Medicaid recipients, typically for an administrative fee, as well as the visit payment. PCCM programs have been successful in increasing access to primary care physicians and creating medical homes. However, medical homes have had varying results regarding the cost of care.[2]

Medical Home Utilization

Alliance member medical home utilization was measured using two factors: (1) the assignment of a PCP upon enrollment and (2) the Alliance member's use of this provider for services. For primary care, each member selected (or was assigned) a PCP or clinic located closest to their home. In the first year of operation, 100% of the Alliance members were assigned to a PCP/medical home.

Alliance member medical home utilization was higher than anticipated. Overall, 54 percent of all provider services were received at an enrollee's medical home. The remaining visits were divided between the Emergency Department (ED) and a non-medical home provider. Please refer to Chart 5.2.



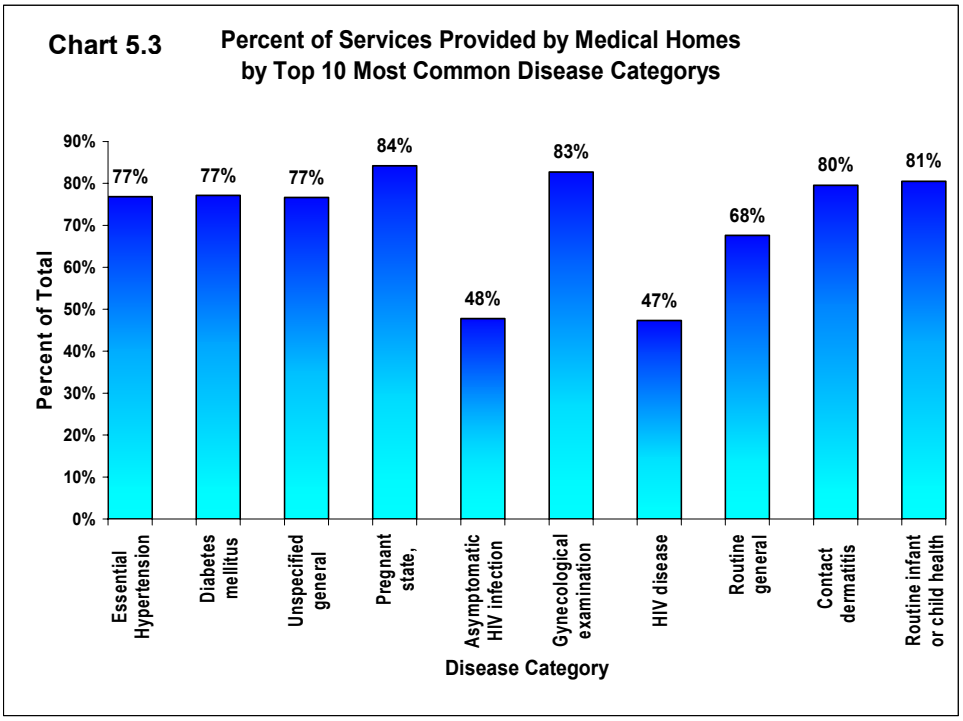
Utilization of Medical Homes

Treatment for the top ten most common diagnoses from paid claims for the first year was predominantly provided at the enrollee's medical home. This is illustrated in Chart 5.3. Of significance were the services provided for the following diagnoses:

- Hypertension
- Diabetes
- General Medical Exam.

Chronic conditions had the highest treatment frequency at medical homes, with the exception of medical examinations and prenatal care visits. Treatment for HIV had the lowest frequency for treatment by medical home providers within the Alliance. It is not possible, at present, to determine how many other services were coordinated and provided with treatment for each of these conditions.

[2] Joanne Rawlings-Sekunda, Deborah Curtis and Neva Kaye, *Emerging Practices in Medicaid Primary Care Case Management Programs* produced for the U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation (Portland, ME: National Academy of State Health Policy, 2001).



Source: CHP Claims data, date of service: 6/1/02 to 5/31/02

The majority of Alliance members with chronic diseases received care in their medical homes. Hypertension and diabetes were the most frequently occurring chronic conditions. While this is a welcome finding for the first year of the Alliance, we are unable to determine the extent to which overall coordination of services occurred. Currently, we do not have a definition of the Alliance medical home or an outline of the service structure of this model. However, the Alliance members' willingness to seek care at a primary site provides a potentially convenient location to coordinate all primary care services. This also enables implementation of a medical home model that will meet the needs of the Alliance program and its members.

Specialty Care

In any integrated healthcare delivery system, primary care services need to be supplemented by appropriate specialty care providers that are able to meet the more complex healthcare needs of patients. The Alliance made sustained efforts to ensure that an adequate number of specialty care providers are available within the network.

Table 5.1 presents the key specialty provider categories and the number of providers available in each category, as well as the number of enrollees per speciality care provider as of July 2002.

Table 5.1 Alliance Provider Network as of May 2002

Provider Category	Provider Count	* Number of enrollees per provider	National Community Rates People per provider
Primary Care Providers	216	132	
Speciaities			
General Surgery	27	1,057	10,000
Pediatric Surgery	17	1,679	
Surgical Subspecialties	84	339	
Cardiology	21	1,359	25,000
Gastroenterology (including pediatrics)	20	1,427	25,000
Dermatology	11	2,596	40,000
Oncology/Hematology (including pediatrics)	32	892	
Urology (including pediatrics)	12	2,379	30,000
Ophthalmology	30	951	20,000

*Enrollee ratios are based on total program enrollment of 28,512 as of May 2002. The fact that pediatric patients comprise less than 10% of the total enrollment must be considered when interpreting the numbers above.

The numbers show that the Alliance made significant progress in providing specialist services to the District's eligible uninsured population. However, there are still certain specialties where continued efforts are required. Through collaborative efforts between the HCSNA and the Alliance, these and other issues regarding access to care services are being examined and addressed.

DC General Specialty Clinic

While the expansion in the overall network of specialty providers was highlighted above, it must be emphasized that the Alliance program retained its Specialty Services Clinic on the grounds of DC General Hospital. As in the previous PBC system, this clinic provides multiple specialty services at one site and continues to serve a large volume of patients daily. Since the start of the program, detailed reports have been prepared outlining the volume of patients receiving services at this clinic. Comparison of service volume between that of the Alliance in Year 1 and that provided by the PBC in the previous year should be made with caution. Because the DCGH volume includes services for people who are not eligible for the Alliance, one would expect the volume of services delivered by the PBC to be substantially higher in many specialty areas.

Emergency and Trauma Services

One of the major changes that occurred with the implementation of the Alliance program was the transformation of a hospital-based ER at DC General hospital into a free-standing ER that required transferal of patients needing hospitalization. To monitor this transition, a focused ER Initiative was implemented by HCSNA. Details on this initiative and the resulting improvements are discussed in another section of this report. As part of this transition, the Alliance continues to provide emergency care services on the grounds of DC General Hospital. Trauma services are now provided at George Washington University Hospital, Children's NMC, Providence Hospital, and Howard University Hospital.

Emergency Room Wait Times

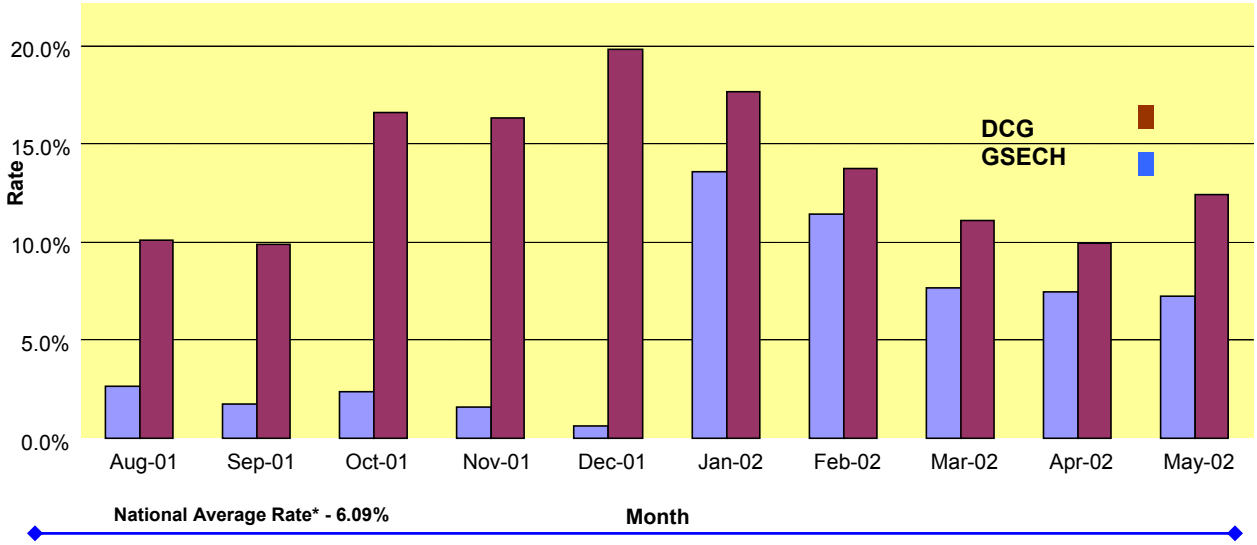
In addition to the appropriate numbers of primary care and specialty providers in the network, Alliance members are also entitled to quick access to emergency services. Recognizing the importance of this issue, the Alliance has identified that the percentage of patients waiting greater than 6 hours in the ERs will be used as a core indicator of Alliance performance. Table 5.2 captures the average result for DC General and Greater Southeast Hospital ERs from August 2001, when the reporting initiative was implemented, to May 2002.

To demonstrate the improvements that have occurred in this indicator, the information is presented on a month-to-month basis in Chart 5.4. The low values in the initial two months of measurement are indicators of the

Table 5.2 Percent of Patients Waiting More than Six Hours in the ER: August 2001 – May 2002

Indicator	GSCH Average	DCGH Average
Rate of patients waiting more than 6 hours in the ER from registration to disposition.	**6.4%**	**13.8%**

Chart 5.4 **GSECH and DC General Emergency Departments**
Percent of Patients Waiting More than Six Hours
August 2001- May 2002



issues faced early in the process of capturing and reporting accurate information. Since December, however, the rate has declined dramatically due to various focused quality and process improvement initiatives implemented by the Alliance. The results were compared and trended against the national benchmark for the indicator (6.1%) obtained from the Maryland Hospital Association's QIPO Aggregate database. The database is based on reporting from 484 emergency facilities across the country.

QUALITY OF CARE

Quality of care services provided to enrolled members of any healthcare program is an important, but difficult area to evaluate. Measurement is all the more complicated in the Alliance population where members frequently move in and out of the system due

Table 5.3 QUALITY MONITORING MEASURES

Indicator	Data Source	Numerator	Denominator	Result
Outpatient Care				
Rate of primary care visits occurring at the Alliance community clinics per thousand Alliance enrollees	Alliance Claims	34,295 primary care visits	37,614 enrollees	912 per 1000
Percent of overall outpatient services provided through the assigned medical home/PCP	Alliance Claims	25,145 medical home visits	46,810 outpatient visits	54 %
Rate of ER visits per thousand Alliance enrollees	Alliance Claims	12,515 ER visits	37,614 enrollees	332 per 1000
Percent of cholesterol screen tests performed among enrolled patients with cardiovascular disease	Alliance Claims	812 tests	6478 patients with cardiac disease	13 %
Percent of HbA1c tests performed among enrolled Diabetics	Alliance Claims	795 tests	2,343 diabetics	34 %
Mammography rate in women 50 years or older	Alliance Claims	644 tests	4,469 women aged 50 years or older	14%
Inpatient Care				
Average length of stay for hospital inpatient admissions	Alliance Claims	Based on total admissions and total days spent in the hospital		5.96
Rate of unscheduled hospital readmissions within 60 days of discharge	Alliance Claims	172 readmissions	1,621 inpatient discharges	11 %
Rate of inpatient discharges at Alliance hospitals per thousand Alliance enrollees	Alliance Claims	1,621 inpatient discharges	37,614 enrollees	43 per 1000

to eligibility determinations. The assessment of quality may involve the review of processes or an assessment of clinical outcomes. A third component is the patient's satisfaction with the care experience which is addressed in a separate section.

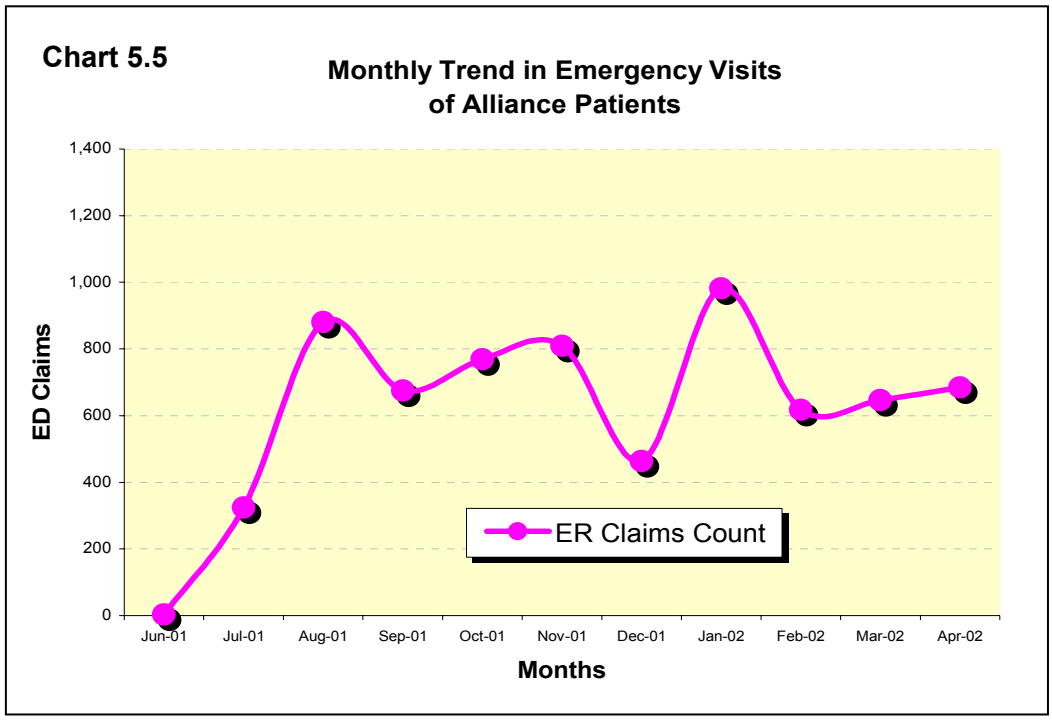
For the initial phase of the Alliance program implementation, the focus was on developing an infrastructure for appropriate care delivery. Therefore, most of the indicators that are being tracked are indicators of process.

Results for indicators where data is currently available are presented in the tables that follow. These results are based on claims submitted and paid as of October 1, 2002, and due to the claims lag, do not reflect all services provided during the defined time period.

Additionally, services have been provided through other hospitals in the region that were not initially part of the Alliance. Through special settlements, services provided by these hospitals or for special populations such as DOC patients have been paid for through the Alliance program. Since detailed claims information for these services is unavailable, it was not possible to include these categories for many of the quality indicators mentioned earlier. However, the

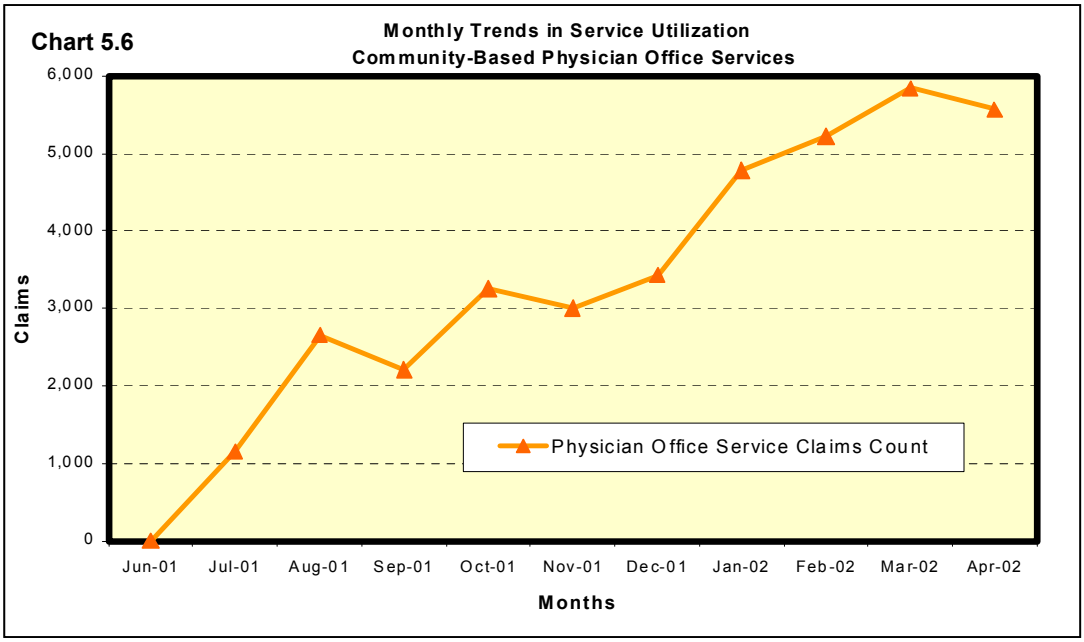
Table 5.4 Quality Monitoring Measures
Including Services Provided to the DOC and through Special Settlements

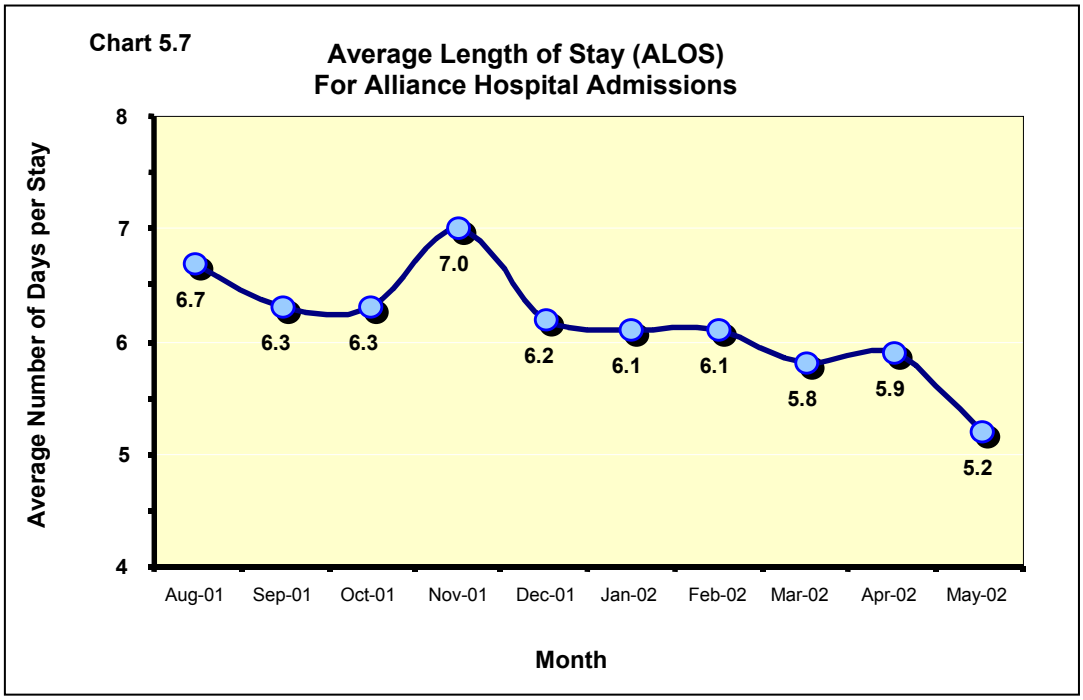
Indicator	Data Source	Numerator	Denominator	Result
Rate of ER visits per thousand Alliance enrollees	Alliance Claims, Settlement Data, and Corrections Data	15,016 ER visits	37,614 enrollees	399 per 1000
Rate of inpatient discharges at Alliance hospitals per thousand Alliance enrollees	Alliance Claims, Settlement Data and Corrections Data	2128 discharges	37,614 enrollees	57 per 1000



two areas where the data could be incorporated into the indicators are in the area of total inpatient utilization and emergency department utilization. The results, with the inclusion of these additional services, are presented in Table 5.4.

Note that the increase in community-based physician services as shown in Chart 5.6 was associated with a relative stabilization of ER use for the same time period as indicated in Chart 5.5. It is hoped that this trend will continue and that patients will seek care in a primary care setting rather than in the District's emergency rooms.





Information in the graphs depicting monthly trends were obtained from the Alliance claims data stored in the HCSNA data warehouse and do not include settlement claims since the required detail and monthly distribution was unavailable. However, the progress and improvement made through the first year of the program is clearly evident. Similar improvements were also seen in the total number of primary care visits that were provided to Alliance enrollees (Chart 5.6).

The increase in community-based service utilization is a result of a combination of factors, including improved outreach, and an increased number of network providers and clinics. Regardless of the included data sources, the results provide a reasonable depiction of performance in the first year of the program and allow the identification of Year 2 priorities.

Another valuable measure is the monthly trend in the average length of stay for inpatients (ALOS). This indicator of inpatient care for Alliance patients has fallen significantly since the start of the program as depicted in Chart 5.7.

Customer Satisfaction

Another important method by which the overall performance of the Alliance can be measured, particularly the quality of services, is through indicators of customer and provider satisfaction. Data for these types of measures can be collected from complaints and customer service logs, and from direct patient satisfaction surveys. The Alliance recently completed a comprehensive satisfaction survey for adult members of the program using the Consumer Assessment of Health Plans Survey (CAHPS®) methodology. Some key highlights from this survey are presented in Table 5.5. The response rate for the survey was 33 percent and represents a random sample of members enrolled in the Alliance. The survey indicates that the overall satisfaction with the program is high, although there are specific areas, such as accessing care services in a timely manner, where improvement is needed in resolving access issues.

Table 5.5 Patient Satisfaction Survey

Indicator	Result
Percent of respondents giving the program overall satisfaction ratings of at least an "8" on a scale of "0 to 10"	71%
Percent of respondents that reported the physician provided to them met their cultural needs	94%
Percent of respondents reporting that the care they received at their doctor's office was better than the care they received at an emergency room	43%
Percent of Alliance enrollees that stated they usually or always are able to get care quickly with some or little problems	64 %

FINANCIAL

The Fiscal Budget for the DC Healthcare Alliance for Contract Year 1 (June 2001 – May 2002) was $81,605,327. Approximately 72 percent of the budget was allocated for health care services and the remaining 28 percent allocated for the School Health Program, pharmaceutical dispensing, supplemental healthcare services that include the Department of Corrections, and administrative start-up cost. The Year 1 Budget called for funds to be distributed as illustrated in Chart 5.8.

Itemization of the actual expenditures for the first year of the contract indicates that approximately 70 percent of the costs were for healthcare services, and the remaining 30 percent for other components of the contract. The financial data in Chart 5.9 represent expenditures as of May 31, 2002. However, these data are preliminary and are subject to change based on completion of the annual reconciliation. The final report will be presented at the end of the fiscal year.

Chart 5.8 Year 1 Itemized Budget of the DC Healthcare Alliance
Total Budget = $81,605,327

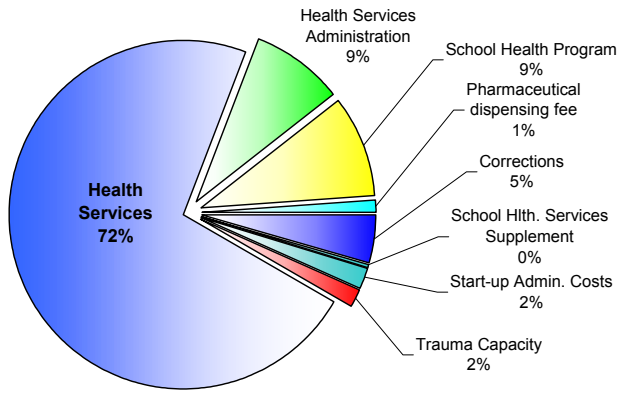
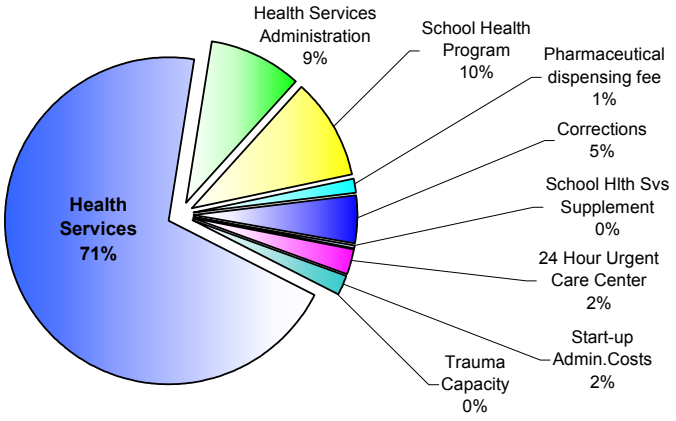


Chart 5.9 Year 1 Itemized Expenditures of the DC Healthcare Alliance



Recommendations

The results presented in the tables and charts demonstrate that the Alliance has made significant progress in its first year of existence in key areas of quality and performance. The results also indicate that there is also opportunity for improvements and enhancements in the coming years. Based on the initial baseline results, the following are the areas where the HCSNA and the Alliance will need to focus its performance improvement efforts in the future:

- Identify and implement strategies for improving access to services in certain specialty provider categories such as dentistry.
- Continue to decrease Emergency Department wait times through enhanced patient flow process and improved follow-up care.
- Increase the rate of primary care and preventive care visits through the appropriate utilization of the medical home, simultaneously decreasing inappropriate utilization of the ER and the hospital.
- Increase preventive screenings such as mammography rates, cholesterol screening for patients with evidence of cardiac disease, and HbA1c tests in diabetics.
- Improve patient satisfaction with care provided through the Alliance particularly in areas such as timeliness and convenience of care services in the primary care setting.
- Continue to enhance the process of data collection and reporting with a focus on indicators of health outcomes.
- Establish thresholds and goals for each of the performance indicators based upon baseline results and national/regional benchmarks.

Recommendations Specific to Medical Homes

- Expand the current member satisfaction surveys to include medical home queries.
- Continue to educate Alliance members regarding their medical home and the services available.
- Define the medical home model for use with the Alliance population.
- Create the organizational infrastructure required to support medical home use in the community.
- Determine services that will be provided by the medical home and serve as the basis for the coordination of primary care.
- Develop a plan for implementing the infrastructure to assess and coordinate services within each medical home and the surrounding community.
- Continue to educate providers on their role as a medical home provider and the range of support services available through the Alliance.
- Empower medical home providers to perform prior authorization to better manage the delivery of care through appropriate referrals and service.
- Implement an expanded performance measurement system along with appropriate benchmarks and quality strategies.
- Continue to measure medical home use by Alliance members: group and measure the coordination and performance of services by diagnosis and medical home; spot check the availability of PCPs including their capacity to care for new members; and perform random medical record reviews to substantiate findings.